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International Society for Traumatic Stress Studies Meets

—Conferees mull problems of fragmentation and integration

By EE

The icon used for the 19th Annual Meeting of the ISTSS was governed by the theme “Fragmentation and Integration in the Wake of Psychological Trauma.” Lofty and abstract except for the logo, appearing behind the podium and on the conference programs, a photograph of a curving road composed of uneven stone slabs, the proverbial Rocky Road, which didn’t look friendly to the disabled in wheelchairs and walkers, but was a wonderful image of ordered unevenness. Rumors in the audience were that this year’s president, Oono van der Hart, had a lot to do with the selection of programs and the design of the conference. The principle speaker in the opening plenary address was Laura Prescott with a poetic and profound voice of someone who had been repeatedly sexually abused in childhood, went through successions of treatments and then on to survive and become an international spokesperson for women and children who are afflicted. And, although she told some horrific stories, she spoke with such grace and humility that she opened our hearts rather than tweaking our defenses. The title of her talk was, “Surviving Violence and Shattering Silence.” She urged her audience of mental health caregivers to place the client at the center of the healing process, to make a commitment to dialog with the client. She advocated for patient input, rather than “evaluation in the absence of patient feedback.”

As Ms Prescott said, “I was at my highest risk [for suicide] when I was most compliant.” She spoke with eloquence and good humor ending her address with a poem and a simple slogan “Recovery is possible for everyone.” Sounds idealistic, but this comes from a woman who has bucked great odds to be addressing the society.



Activist Laura Prescott after her well-crafted 2003 ISTSS Keynote address in Chicago.

Ms Prescott did make one point that deserves a comment. She observed in what seemed a rather flippant way that the concern in our community for secondary traumatization implies that clients with PTSD are contagious. This is not the case. Secondary or vicarious traumatization occurs as the result of long term work with many clients in therapists whose self care techniques are insufficient to cope with the accumulation of imagery and stress. It may come from many encounters over a brief time in the wake of a disaster, or over years in the case of caregivers who make PTSD their focus.

Therapeutic Relationships

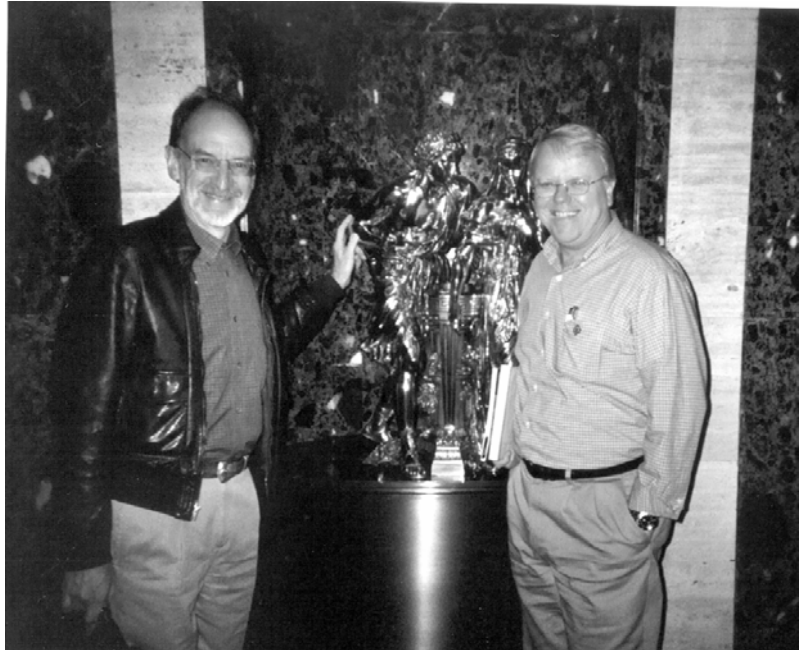
Ms Prescott made a strong pitch for mental health caregivers focusing on the quality of their relationships with clients. As she said, recovery comes from inspiration. Her call coincided with what was for me the highlight of the conference, a pre-conference seminar Thursday morning which featured three
(Continued on page 3, See *ISTSS Meet*)

ISTSS Celebrity Scenes from Chicago Nightlife.

Chicago

The best event at the conference was the City of Chicago. This author received a tour from Chicago native, Norma Rolsfen, an oncology nurse who had once worked at Bailey Buchet House in Seattle. We toured together with former Chicago Residents Tom Schumacher and Michelle Klevens. The city felt alive and vital in its ethnic neighborhoods (Michelle, a former WDVA therapist with the Bill Maier contract in Sequim, was staffing a poster session devoted to the Prazosin research being conducted at the Seattle VAMC.) The tour followed a convivial evening meal at the *Rosebud*, a restaurant in the Italian district of the Windy City. The *Rosebud* was where Frank Sinatra used to hang out and there was a large portrait of Old Blue Eyes overlooking the dining room. People in the Midwest eat larger portions, I was told on the flight home by a salesman who seemed to know from experience. EE ##

Seattle Travelers Seeking Wisdom



Seen posing in the lobby of the classy Palmer House in Chicago while attending the ISTSS meeting are Tom Schumacher of the Washington Department of Veteran Affairs and Frank Kokorowski of the King County Veterans Program. They were indeed as happy as they appear above, having been stimulated by power point lectures. ##



Seen below are revelers at Chicago's famous *Rosebud* restaurant where Old Blue Eyes himself hung out. From left to right are Emmett Early, the RAQ Editor and roving reporter, beaming before a plate of chicken cacciatore, and Miles McFall, Seattle VA psychologist and one of the cited organizers of the ISTSS meeting and a presenter at a pre-meeting workshop "The Joint VA/DoD Clinical Practice Guidelines for Traumatic Stress." On Miles' left is a Chicago native Christine Mannarelli, a friend of Michele Klevens. On Christine's left, bringing up the rear, is Tom Schumacher. The man standing behind may or may not be a representative of Homeland Security. Seated left to right across the bounteous *Rosebud* table are Michele Klevens, inciter of the evening's events. She is now working with the Prazosin program at the Seattle VA hospital. Next to Michele is Elaine Peskind, M.D., who works in the VA's Alzheimer's research program, and Victoria McKeever, a psychologist researcher with the VA PTSD Program, formerly with the National Center for PTSD Research. Seated next to her is Eve Davison, also a psychologist with the Boston-based NCPTSD. Photo by Chicago native, Norma Rolsfen. ##

(ISTSS Meet, continued from page 1)

speakers focusing on the theme of "Establishing and Protecting the Relationship with Trauma Clients." The three speakers, Constance Dalenberg, Steven Gold, and Christine Courtois, presented in a pleasant nonlinear fashion, interweaving their slides and commentary, although they had separate papers. They addressed different aspects of the tricky topic of countertransference and what to do with it. Dr. Courtois spoke eloquently on the effects of clinician silence in response to client tales of trauma. She asserted that the client needs clarification of what the therapist thinks, otherwise, she said, the client is vulnerable to shame. Shame in the client, which is usually private, can be helped, she said, if it is made into a symptom instead of a state of being.

Dr. Stevens went further, stating that "the most important thing in therapy is engaging [in dialog] with the client." The presenters agreed that the symptoms of avoidance are problems that client and therapist must struggle with together. Therapist emotional reactions, especially anger, can be used therapeutically if they model tolerance, the ability to stay connected in the face of strong emotion.

Monsters in Memory

The Thursday morning speakers also addressed an important topic, particularly in children, of memory confabulation, such as the client adding fantastic elements when describing traumatic memories. Dr. Stevens gave the example of the child traumatized by a dog. Monsters are real because they express the emotional response of the child. That it can't be true, is only because we, the therapists, don't want it to be true. This is similar to this attendee's experience with client feeling statements, which are sometimes hyperbole, sometimes stories that are more feeling-based than factual. The speaker used the example of the boy trapped on a workbench by a bull mastiff in a garage, watching as the dog mangled the family cat. Yes, monsters are real.

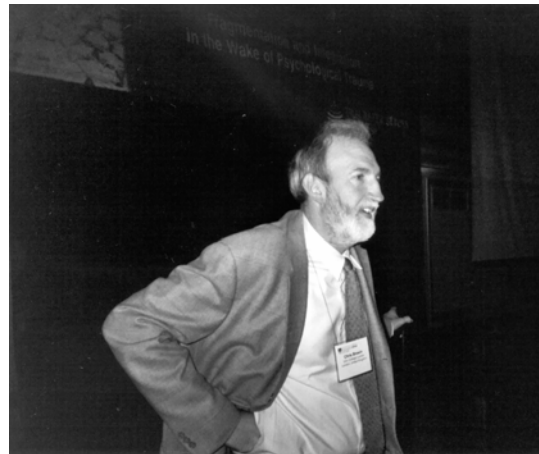
SAM and VAM

Emphases on therapeutic relationship was followed by a stimulating lecture on research on the relationship between memory and identity with a new perspective on psychological trauma and treatment. Chris Brewin of the University College of London presented a theory describing two separate types of memory: Verbally Accessible Memory (VAM) and Situational Accessible Memory (SAM). With the former one thinks, ruminates and experiences guilt, with the other one deals with images and primitive emotions.

Importantly, Dr. Brewin pointed out that SAM is experienced as happening in the present, is connected to amygdala, and becomes the source of flashbacks. VAM, on the other hand, is a product of the hippocampus and is not just verbal, but also constructive and capable of influencing SAM, making imaginal changes to distinctive images as time goes by.

What seemed most significant about the distinction between verbal and situational accessible memories is that the former is retrievable and the later is autonomous. That situational memory is autonomous is significant particularly when one thinks of the identity of one who is having intrusive situational memory. It is experienced as if it were in the present and would tend over time to leave the survivor of trauma with a sense of helplessness when it comes to controlling the intrusions.

Regarding treatment, Dr. Brewin described the value of cognitive behavioral focus on "hot spots", in which detailed verbal memories trigger SAM images, which in turn create alternative memory records, recoding SAM with detailed narrative, thereby creating new verbally accessible memory. He acknowledged, in response to a question from the audience that cognitive researchers do get "sniffy" about the value of relationship in psychotherapy. ##



Dr. Chris Brewin of University of London found his cognitive colleagues "sniffy" about the subject of the healing value of relationship in psychotherapy.

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave or warn us about, the RAQ may play a role. Your contributions will make a difference. Email or write to WDVA.

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Psychiatry Journal Publishes Guidelines for Suicide Assessment and Treatment

The American Journal of Psychiatry periodically publishes special editions to its usual monthly journal offerings. These offerings are described as "Practice Guidelines," intended not to be a standard of treatment or assessment, for standards change, but rather as a guide, in this case for psychiatrists evaluating and treating adults on the subject of suicide. The 60 page supplement to the November, 2003 issue [160(11)] provides a learning tool for beginning clinicians and a consciousness-raising review for the yeomen. Table one on page 4, "Characteristics Evaluated in the Psychiatric Assessment of Patients with Suicidal Behavior," provides an excellent checklist of items to consider when suicidal concern arises.

The Practice Guideline was put together by a work group, chaired by Douglas Jacobs, MD. The authors raise a signal of concern about the use of so-called suicide contracts. "The suicide prevention contract, or 'no-harm contract,' is commonly used in clinical practice but should not be considered as a substitute for a careful clinical assessment.... A patient's willingness (or reluctance) to enter into an oral or a written suicide prevention contract should not be viewed as an absolute indicator of suitability for discharge (or hospitalization).... In addition, such contracts are not recommended for use with patients who are agitated, psychotic, impulsive, or under the influence of an intoxicating substance.... Furthermore, since suicide prevention contracts are dependent on an established physician-patient relationship, they are not recommended for use in emergency settings or with newly admitted or unknown inpatients..." (p. 5).

The authors also raise an important point of confidentiality, should a client commit suicide. "The psychiatrist should be aware that patient confidentiality extends beyond the patient's death and that the usual provisions relating to medical records still apply" (p. 6).

In conducting an assessment of a client, the clinician is advised that "A history of past suicide attempts is one of the most significant risk factors for suicide, and this risk may be increased by more serious, more frequent, or more recent attempts" (p. 8).

In Table 3, on page 10, the authors offer an extensive list of "Questions that may be helpful in inquiring about specific aspects of suicidal thought, plans, and behaviors." Reading through the list, one gets that chill of ominousness imagining how clients have responded. Questions like, "Are there other people you would want to die with you?" Table 4, on page 12, the authors list "Factors associated with an increased Risk for Suicide," including such factors as childhood traumas, physical illness and cognitive decline.

Suicide Demographics

The demographics of suicide are always of interest. Here again white males dominate. "In the United States, death by suicide is more frequent in men than in women, with the suicide rate in males approximately four times that in females..." (p. 14). Among males, Natives and African-Americans are at greater risk in adolescence and young adulthood, whereas white males increase in suicide risk into senescence. Suicidal clients are at higher risk of carrying the act through if they have family members who have committed suicide. "Overall, it appears that the risk of suicidal behaviors among family members of suicidal individuals is about 4.5 times that observed in relatives of nonsuicidal subjects..." (p. 24).

Table 8 on page 31, gives us a kind of flow chart, although it is structured as a list of "Guidelines for selecting a treatment setting for patients at risk for suicide or suicidal behaviors." The list includes when admission to a hospital is "generally indicated," "may be necessary," and when release from the hospital is indicated. The last item on the "may be necessary" category is a dicey one: "In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others, suggests a high level of suicide risk and a recent acute increase in risk."

CE Credits

The Practice Guidelines presents various treatment modalities and procedures for documentation of the clinician's rational and actions. And to document their own thoroughness, the authors list a whopping 660 references.

The American Journal of Psychiatry Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors is recommended for staff in-service training with the tables cut and pasted into every clinicians workbooks. Checklists are best used in life-and-death situations when emotional tension is high and the cost of an error can be significant. It prevents sleepless nights when the clinician second guesses the process and worries that he or she may be called at 3:00 AM. Going along with the "Questions that May be Helpful" table, is the nagging dog that hounds veteran clinicians, "Are there things that you've been feeling guilty about or blaming yourself for?"

Copies of the Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors are available directly from the Journal. CE credits may be available on line from www.psych.org/cme. EE ##

Veteran Twin Studies Produce Insight into Combat, PTSD, and Co-morbid Disorders

A workshop at the Chicago meeting of the International Society for Traumatic Stress Studies featured presentations by researchers who, not coincidentally, are studying the genetic influence of PTSD. The workshop title promised to address a sensitive topic "Predisposing Risk Factors for Trauma Exposure and PTSD." One of the presenters, along with Roger Pitman and Mark Miller, was Karestan Koenen, of the National Center for PTSD, who was principle author of the lead article in the October *Journal of Traumatic Stress* [2003, 16(5), 433-438]. Although it sported an awkward title, "Co-Twin Control Study of Relationships Among Combat Exposure, Combat-Related PTSD, and Other Mental Disorder," the topic was compelling.

The Koenen, et al, study used 1,874 monozygotic twin pairs from the VET Registry "for whom complete DSM-III-R diagnostic information was available."

Koenen, et al, explained, "The VET (Vietnam Era Twin) Registry, assembled from Department of Defense computerized military records, is a nationally distributed cohort, comprised of male-male twin pairs born between 1939 and 1957 in which both members served in the military during the Vietnam War era..." (p. 434).

Koenen, et al, described the purpose of their study. "In this study, we use monozygotic...twins in a co-twin control analysis for the influence of shared vulnerability and examine whether combat exposure and C-PTSD (PTSD from combat) have significant effects on risk for the following five mental disorders: major depression, alcohol dependence, drug dependence, cannabis dependence, and tobacco dependence" (p. 434). The authors make an interesting observation in their results section: "For each specific diagnosis, the twin with the diagnosis had a higher mean level of combat exposure and a higher prevalence of C-PTSD than the twin without the diagnosis" (p. 435).

More specifically, the authors analyze their results: "MZ twins who had lifetime major depression, drug dependence, or tobacco dependence were more likely to have been exposed to combat and C-PTSD than their co-twins who did not have the disorder. Moreover, the effects of combat exposure on risk for alcohol dependence and cannabis dependence persisted after controlling for C-PTSD, indicating that combat exposure has a unique effect on risk for these disorders" p. 436).

PTSD Predicts Tobacco Dependence

The research revealed that combat-related PTSD was "a significant predictor of major depression and tobacco dependence after adjusting for combat exposure." Thus, the authors explain, it is the PTSD resulting from combat, and not the combat itself, that increases the risk for these disorders. They also observed that it was combat exposure itself, after PTSD was controlled, that increased risk for "alcohol, drug and cannabis dependence," and observed further that this result confirmed previous research that produced the same findings (p. 436).

Koenen, et al, caution that no causal link can be inferred between combat exposure, PTSD, and other mental disorders that they studied, because they did not control for other non-shared environmental factors. They summarize their research findings with a statement of what they can conclude. "Our findings indicate that (combat related PTSD) co-morbidity is not merely the product of previously uncontrolled for shared vulnerability, but that combat exposure and C-PTSD have nonshared environmentally mediated effects of risk for other mental disorder. Moreover combat exposure and C-PTSD

differentially affect risk for these disorders. Combat exposure uniquely increases risk for substance dependence, while C-PTSD uniquely increases risk for major depression and tobacco dependence" (p. 438).

Service Connected Tobacco Dependence

Such a conclusion by Koenen, et al, also lends argument to the issue of tobacco-related illnesses being given service-connected support, particularly in the presence of combat related PTSD. Even further, it suggests that other forms of substance dependence, including alcohol dependence, may be arguably connected directly to combat exposure, with or without the presence of PTSD.

The argument contends that in previous wars, together with the free distribution of cigarettes in C-Rations and the ready, cheap access to alcohol in R&R centers and base camps, prolonged combat made for the formation of coping habits in vulnerable individuals under stress in late adolescence.

It seems that with the added risk for PTSD comes an even greater risk for substance dependencies, particularly tobacco dependence. By listing tobacco dependence as "a mental disorder," Koenen, et al, lend credence to the argument for service connection. EE ##

"For each specific diagnosis, the twin with the diagnosis had a higher mean level of combat exposure and a higher prevalence of C-PTSD than the twin without the diagnosis"

Tom's Intrusive Thoughts & The News

By Tom Schumacher

PTSD Contractor Conference Planned for March

The 2004 PTSD Contractors Conference is in the schedule book for early spring. Again we trek to the shores of Lake Chelan and Campbell's Resort. This marks the sixth time in 20 years that our meeting is being held at Campbell's. The agenda is already taking shape and topics include, standards of practice for our program, ethical considerations, our unique HIPAA questions and answers (maybe), discussions about the current war deployment and methods of management upon their return. Also presentations from VAMC Seattle regarding the latest study that will examine the use of Prazosin with veterans returning from Iraq who suffer from PTSD nightmares. We will have reports from the October 2003 ISTSS Conference held in Chicago.

The conference is exclusively for WDVA PTSD Contractors and invited guests who offer our providers with important treatment and related news. The goal is not only to learn new things, but to network and relax in the company of 26 fellow WDVA Contractors. This year's meeting appears to be one that will be marked by retirements of some of the staff members of our contractors.

PTSD Program. WDVA Website Expansion

Quietly, the WDVA Internet Website (www.dva.wa.gov) has been refining itself. While I am certain there are many staff members who have had input into the current website offerings, clearly Miriam Young is the steward of this electronic source of news and information. Logging-on allows the visitor to look at every aspect of the Department. Contractors can even download required reporting forms, and the latest news and pictures of the massive building project at the Veterans Home (Retsil). On the PTSD Website (simply click on "PTSD" on the banner that is at the top of the opening page) one can find a description of the PTSD Program, a review of the syndrome PTSD, a list of counties served, the phone numbers of all contract providers, the telephone numbers and locations of the state's Vet Centers, and most recently the last three editions of the *Repetition and Avoidance Quarterly*. I was told that the PTSD program was the 10th most examined item within the agency's overall site, and that 80% of the visitors opened the contractor name and address section. Over one-half also opened an edition of the *RAQ*.

The War in Iraq

Many of us have expressed concern for the ongoing deployment of active duty soldiers, sailors, and airman of Washington to the war zone and support locations. The inclusion of Washington State National Guard and members of various reserve units, has been reminiscent of the deployment a decade ago. This time the outcome of the war is seemingly more nebulous and hazardous over a

protracted period. We are also growing increasingly aware of the fact that family members of deployed unit members are being exposed to many new and difficult experiences.

WDVA has been working with the federal VA and Madigan Army Hospital to better understand the full impact of these realities. Our PTSD Program has actually been providing services for some of these families as well as some of the returning unit members. Naturally, all providers are being encouraged to see these returnees and those family members who need help during and after the deployment.

The federal VA Medical Centers and Vet Centers are also being told that they may work with anyone returning from this war. Many troops will be returning to Washington State as the initial deployment group is rotated for a rest. Some of these may come home to Washington for leave or discharge to their home state. Contractors are encouraged to network with the federal service providers in order to find the most effective treatment and services for these clients. Some may need to file claims for conditions related to their service. Veteran Service Officers throughout the state are preparing for their return.

Many of us have witnessed the impact of this war upon veterans of previous conflicts. In my own small client case load, veterans seem to have experienced an increase in symptoms. The new clients coming in include not only Vietnam or Desert Storm veterans, but veterans of the Korean War. This has been remarkable in many respects. Also noteworthy, all of the new clients I am seeing have never before sought services. The current war appears to represent the perfect trigger for their own war experience reactions. For Korean and Vietnam veterans it may well be the fact that there remains a lack of closure that may extend into an occupation for years. "Protracted agony", as one new veteran client labeled the current war.

PTSD Program Lunches New Outcome Study

While not earthshaking in scope, the current examination of the WDVA PTSD Program attempts to look at the impact of treatment upon war veterans. Korean, Vietnam, and Gulf War combat veterans make up the 462 subjects. The survey is a clinician review of objective changes found in individual clients on several variables. Time (duration since intake) in treatment will be examined to determine at what point in treatment critical changes in the veterans' lives seem to occur.

Since state government is very much interested in "cost benefit analysis," a strong effort is being made to look at cost of care, return on investment, and who is pays for the treatment in the long term. The capacity to remain or return to employment, even if holding service connected disabilities, is also being surveyed. An issue that has been a matter of sometimes heated debate among contractors and others—Should a veteran who is 100% service connection, with permanent and total (P&T) disability, be allowed to work?—is being considered directly as well. We have learned that some veterans can do limited work, however actual earnings may not exceed the poverty level. Once this is exceeded, disability payments may be reduced by the VA.

Voluntarism and family roles played will also be examined in the current survey. A report of the survey results will be available in the next edition of the *RAQ*.##

Reflections of Trauma in Literature



Above are Harold Kudler with Jonathan Shay after their inspiring workshop on trauma in literature. Dr. Kudler presented his thesis on the perspective of trauma in Shakespeare's *Macbeth*. Dr. Shay is the author of *Achilles in Vietnam* and *Odysseus in America*, books which would make a nice Christmas stocking stuffers for a deserving veteran or psychotherapist.

Harold Kudler, MD, conducted a literary workshop at the annual ISTSS meeting in Chicago, examining Shakespeare's *Macbeth* from the perspective of a modern trauma understanding. He was quick to point out that the play is not a case study of the man. Quick speaking and eloquent, Dr. Kudler quoted from the play as examples of the poet's grasp of mental illness. For example, in Act 5, Scene 3, Macbeth asks the doctor to help Lady Macbeth:

"Canst thou not minister to a mind diseas'd,
Pluck from the memory a rooted sorrow,
Raze out the written troubles of the brain
And with some sweet oblivious antidote
Cleanse the stuff'd bosom of that perilous stuff
Which weighs upon the heart?"

The doctor responds: Therein the patient must minister to himself."
Macbeth then replies defensively, "Throw physic to the dogs—I'll none of it./Come, put mine armour on, give me my staff."

Together with slow, methodical comments from Jonathan Shay, the sprightly Dr. Kudler drew out contrasts between Macbeth's reaction to the death of his spouse to Macduff's reaction to his families' slaughter: and the call of his comrades for revenge, with Macduff saying, "But I must also feel it like a man." EE ##

Ricardo Swain Leaves WDVA

Ricardo Swain, MSW, notified WDVA that he was retiring as a contractor and group therapist. Citing health and family demands, Mr. Swain said that he was planning to continue as a social worker at the Seattle VA Puget Sound Health Care System Addictions Treatment Program. Mr. Swain's first began conducting psychotherapy groups in 1979 when the Seattle Vet Center was inaugurated. ##

Phone numbers for WDVA and King County Veterans counselors and contractors are listed in alphabetical order.

Steve Akers, MSW, Everett.....	425 388 0281
Clark Ashworth, Ph.D., Colville.....	509 684 3200
Wayne Ball, MSW, Chalan & Douglas...	509 667 8828
Bridget Cantrell, Ph.D., Bellingham.....	360 714 1525
Dan Comsia, MA, King County.....	253 840 0116
Paul Daley, Ph.D., Port Angeles.....	360 452 4345
Duane Dolliver, MS, Yakima.....	509 966 7246
Jack Dutro, Ph.D., Aberdeen.....	360 537 9103
Emmett Early, Ph.D., Seattle.....	206 527 4684
Dorothy Hanson, MA., Federal Way	253 841 3297
Tim Hermson, MS, Kennewick.....	509 783 9168
Bruce Harmon, M.Ed., Renton.....	425 277 5616
Bill Johnson, MA, Mount Vernon.....	306 419 3600
Dennis Jones, MA, Mount Vernon.....	360 419 3600
Bob Keller, MA, Olympia.....	360 754 4601
Frank Kokorowski, MSW, King Co VP..	206 296 7565
Bill Maier, MSW, Port Angeles, Sequim..	360 457 0431
Brian Morgan, MS, Omak.....	509 826 0117
Mike Phillips, Psy.D., Issaquah.....	425 392 0271
Dwight Randolph, MA, Seattle.....	206 465 1051
Stephen Riggins, M.Ed., Seattle.....	206 898 1990
Ellen Schwannecke, M.Ed., Ellensburg...	509 925 9861
James Shoop, MS, Mount Vernon.....	360 419 3600
James Sullivan, Ph.D., Port Orchard.....	360 876 2322
Darlene Tewault, MA., Centralia.....	360 330 2832
Tom Wear, Ph.D., Seattle.....	206 527 5382
Stephen Younker, Ed.D., Yakima.....	509 966 7246

WDVA PTSD Program Director:

Tom Schumacher.....	360 586 1076
Pager.....	800 202 9854 or 360 456 9493
Fax.....	360 586 1077

To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's Form DD-214 (discharge). A copy of DD 214 will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used to prove the veteran's military service. You are encouraged to call Tom for additional information.

It is always preferred that the referring person telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are on fixed monthly budgets, however most will work to include new clients.

Some of the program contractors conduct veteran group and individual services, as well as offering family counseling. Limited spouse groups are also held by contractors in selected areas. ##

Movie Review:**A thirty-eight search for a movie—A ‘must see’ for all trauma therapists**

By: Tom Schumacher

The Man in the Glass Booth

During the middle 1960's I first saw this play on the old *Playhouse 90* television series. It was Robert Shaw's, *Man in the Glass Booth*. A stunning bit of work, it bore witness to phenomenon that I would only later come to understand as depicting psychological "splitting". Unlike "doubling," as described by Robert Jay Lifton in his 1986 book, *Nazi Doctors*, where death camp physicians consciously lived two very different life roles—the cultured physician-healer and physician death camp murderer; The phenomenon of splitting is shown to be a largely unconscious process resulting from powerful emotional forces that cannot be reconciled. *Man in the Glass Booth* depicts the extremes to which one man would go to in order to attempt resolution of his tormented survivor guilt, unresolved rage at both victim and villain, and the desire to visit justice upon the play's nascent character, Colonel Karl Dorf.

Man in the Glass Booth was later performed on Broadway, with the lead role played by Leonard Nemoy. Later still the play adapted for film, starring Maximilian Schell. Schell, a native German, does a convincing job playing Mr. Goldman, a wildly successful survivor of the Nazi death camps. In the opening scenes, Goldman's wife has just died. This event triggers deep psychological forces leading Goldman to be progressively transformed by survivor guilt, identification with the aggressor, and other forces, into the much hated Colonel Karl Adolph Dorf, commandant of Goldman's concentration camp.

Goldman's post-trauma life represented survival, resiliency, and transcendence of the death camp terror. A successful adjustment after a tortured youth. Yet, it is Dorf that Goldman is compelled to become. Dorf is evil incarnate, whose use of power was employed to carry out Nazi doctrine, as well as to protect himself and his troops from the war front.

This film should be required viewing for anyone who works with trauma survivors. (See Emmett Early's Review in this edition of *The RAQ*.) This is especially the case when the intricacies of guilt and early life trauma conspire toward self harm, self-deception, and the charting of a life-course that slowly but certainly follows a path to destruction.

Goldman was a child in the death camps, and it is his memory of Dorf vs. Goldman's father (whom Dorf killed) that I believe is formative of Goldman's adult life. Despite using ruthless power himself to create great wealth and success, Goldman is obsessed with his failure to resolve his traumatic experiences and powerless over the images of Dorf's tyrannical control over life and death, especially the killing of Goldman's immedi-

ate family, and Dorf's clever escape from the horrific scene at war's end—a feat that Goldman seems to admire.

In another sense, Goldman needed to resolve two sets of powerful emotions. His drive to *be punished for surviving and for thriving* when so many died. And, an equally powerful drive to expose and kill Dorf for his war crimes.

In the real world after the war, Dorf had in deed escaped and only Goldman could *find* him, bring him to trial, and inflict legal punishment upon him. Since the real Dorf could not be found for punishment, Goldman needed a Dorf to suffer for the sins of the death camp.

However, just to identify with Dorf and suffer quietly was not enough. Goldman required the ultimate sacrifice of himself, and, in Christ-like fashion, he becomes the substitute. The sinner, the lamb, the supplicant, and the judge all in one. The film suggests that Goldman considered some type of *resurrection* after his own death, although defensive humor obscures certainty on this point.

Goldman could only complete his quest for psychiatric peace if he left a clear trail for Israeli Nazi hunters to follow. This required switching identities, altering personal histories, making it appear as though Goldman/Dorf is hiding his former SS officer tattoos, creating a way to explain his prisoner tattoo, as well as exchanging his own medical and dental records with those belonging to Dorf. These things completed—Goldman is now Dorf, and his own "trap" is set. A veritable Garden of Gethsemane!

Once captured and brought to Israel, the ensuing trial offers a forum within which the court considers the extremes of psychic doubling associated with the Holocaust, and the historical role of various stereotypical participants. Shaw weaves wit, horror, madness, and "love" together to explore the dynamics of those insane times.

Eventually Goldman/Dorf falls into a complete catatonic psychosis when Goldman's true identity is revealed. But not before Dorf makes enemies of everyone in the court, telling the reasons he acted the part of a butcher in the war, to include references to Vietnam, and his claim that *love* fueled the Third Reich. In the end, Goldman is neither Goldman nor Dorf, but a Christ-like figure, executed for the sins of all, inside the *Glass Booth*.

The last scene allows Goldman/Dorf to jointly participate in their mutual psychological death. The resolution of survivor guilt and unrepentant (and unpunished) evil have only one place to go. They are welded together and frozen in a stranglehold of each other. We can hear Goldman's tormented auditory hallucinations — hobnail boots marching on cobblestone, the blistering sounds of machine pistol fire, and the screams of victim and villain alike.

(Note: *Man in the Glass Booth* is now available in VCR and DVD formats.) ##

Movie Review:***The Man in the Glass Booth*—Guilt and the Stress of Success**

Reviewed by EE

Guilt was dramatically demonstrated in Robert Shaw's *The Man in the Glass Booth*, which has just been released in video from a 1975 *Playhouse 90* drama, in the film adaptation directed by Arthur Hiller. Guilt is so strong that the identity of the survivor has been fractured. The viewer is drawn into the flux of instability and becomes unsure of who he is. Is the wealthy Jew, Mr. Goldman, really the Nazi camp commandant, Karl Adolf Dorf? The two characters merge ambiguously in the brilliant performance of Maxamilian Schell. The play was adapted to film by Edward Anhalt.

As a Jew, Goldman tortures himself in response to the painful memories involving deaths of loved ones. As Nazi he mocks sentiment and describes himself dryly as a practical soldier avoiding more dangerous duty by killing Jews. He insists that he did his job well.

Mr. Goldman is a brilliant, reckless investor who keeps millions of dollars in cash in his bureau drawers. He converses with his dead wife's ossuary urn and describes her as an anti-Semitic gentile. He views the streets of Manhattan from his penthouse through a telescope and hallucinates seeing his father selling pretzels on the street become a Nazi officer.

When the Israeli agents capture him, is it because Goldman has laid a trail of misinformation that will lead to his trial as the Nazi, Dorf, because he has identified with the aggressor? Or is it as he, Dorf, claims, that he disguised himself as the hapless Jewish inmate, Goldman, at the last minute before the Russians liberated the Death camp?

Guilt as Symptom

For our purposes, as therapists, we question whether our client's failure to succeed (or fall from success) is a product of PTSD in the whims of a failing economy, or is the client avoiding intolerable success? Does he or she drive away loved ones as a product of self contempt, or is PTSD the culprit?

We observe how the Vietnam War has lent itself to guilt by brutal guerrilla tactics, sometimes year-long combat, and individual DEROS, leaving the survivor alone and safe while the war continued. Many of us experience childhood guilt from accidents, death, trauma, religion, or parental mistakes. To experience guilt again as an emerging adult as a product of combat can seal the deal and make guilt a lifelong companion. We can't see the guilt, if it is not identified by the client as a feeling, we must interpret its presence from behavior.

It seems paradoxical or at least ironic that economic security can be stressful. So why is this person who has a secure income and plentiful leisure time so unhappy? Why does the client fantasize suicide and homicide? What is this bitterness that keeps the veteran from enjoying his or her free time?

We identify guilt in the client and say "there it is in your behavior, put it in its proper place and get on with this life of yours"—which is a little like your neighbor telling you to ignore his snarling bull mastiff at the gate.

The question in *The Man in the Glass Booth* is whether survivor's guilt (a term coined by Niederland in Krystal's classic, *Massive Psychic Trauma*) drives the successful Jewish businessman to identify with his oppressor, taking the punishment for the crimes that he witnessed.

Impact of Guilt

To paraphrase the late pioneer war photographer Gerda Taro, "it feels unfair to be alive when so many good people have died." One way to offset survivor's guilt is to continue fighting. Engage in lawsuits with neighbors, fight with rude people in stores and ticket lines, rage on the road or at the VA pharmacy counter, over-react to innuendo, battle the inevitable tide of changing values and customs. What a brave man: he survives Vietnam combat and then tirelessly battles the doctors of disease, the ogres of divorce courts and child custody proceedings, the unfair processes of personnel decisions, zoning ordinances, unconstitutional applications of the law. He doesn't wear a helmet or flak jacket anymore, yet every day he braves metaphorical booby-traps when he goes to the mailbox.

Mr. Goldman in *The Man in the Glass Booth* identifies with Jesus and his last pose passively mimics the crucifixion. It is as if he has split off his aggressive energy and identified with the evil done to him and millions of others. It is not enough to have survived the battlefield, the survivor with guilt would rather fail in quixotic combat than live on in peaceful success.

The treatment of guilt, especially survivor's guilt, must rest on the premise that the client understands the concept and accepts at least in principle the possibility that he is holding himself back. I think of guilt as a negative drive. It detracts from enjoyment, it withholds pleasure, and inhibits success. It is the long distance runner who stops before the finish line, quits when he's ahead, never calls someone he loves, has a migraine on the skating rink.

Guilt must be first identified as a player and then isolated so that it doesn't impact behavior, because we assume guilt that is generated in trauma doesn't go away simply because it is identified. However, its influence can be minimized if it can be prevented from driving behavior.

All this is not to contend that guilt-driven behavior cannot be constructive. There are those who care for the sick and disabled, volunteer for charity efforts, who make major contributions to society, although their acts do not necessarily assuage their guilt, which may ironically be deepened by whatever praise and gratitude may follow. ##

Movie Review:

Clint Eastwood's *Mystic River*—A dark, brilliant study of the life of a trauma survivor and his witnesses

Reviewed by Emmett Early

Clint Eastwood directed *Mystic River*, hopefully not the last of this 71-year-old star's film output, because he seems to get better and more profound with age. With this work he has produced a profound examination of psychological trauma, post 30+ years, in which the victim is leading a sad tense life, and the witnesses, his childhood friends, are again caught up in his fate. Tim Robbins plays the victim, Dave, who was tricked as a child into riding away with two male rapists, one posing as a cop and the other posing as a Catholic priest. The boys had been carving their names into drying cement on a sidewalk. The predators intervened and "arrested" Dave. As they drove off, Dave looked out the window of the car at his friends, Sean and Jimmy. Decades later Sean, played as an adult by Kevin Bacon, is a Boston police detective while Jimmy (Sean Penn) is running a convenience store.

What we see is the long term struggle of one who has been kidnapped and raped, and the fated involvement of those who witnessed his abduction. Clint Eastwood also wrote the music for this work. We see his development from *Absolute Power*, when he wrote *Power Waltz*. This music captivates us with mournful strings in the inevitable flow of events. Dave is anxious and depressed. He has a wife and a son.

The movement of the plot is triggered by the murder of Jimmy's teenaged daughter. Dave is implicated, because he returned home on the night she was murdered, shaken and bloodied by a murder he had committed. He had murdered a child predator in the act of rape. He jerked the guy out of his car and beat him to death. But he could not tell his wife (Marcia Gay Harden) what had happened. She came to believe that he killed Jimmy's daughter and she finally tells Jimmy her suspicions.

Sean is charged with investigating the murder of Jimmy's daughter. Jimmy had been sent to prison for a robbery in which he took the blame and refused to give up his companions in the crime. Sean Penn plays Jimmy with intensity that lights up the movie. He is the friction and sparks of the film in contrast to Tim Robbins matte black.

Laura Linney plays Jimmy's wife. Her last lines take the film to another dimension. They take us unexpectedly into national politics when she tells Jimmy that even if he killed the wrong man in revenge, it's OK, because it's enough that he loves his family and takes action to protect them. ##

Drama Review:

Joan Fiset's *A History of Strangers & Children*

Reviewed by Pat Johnson, WDVA

On Monday, September 15th, I attended Joan Fiset's play at the Odd Duck Studio. I got there a little late, and the others who arrived after all the seats were filled scooted over so I could sit on the aisle steps. The hard floor, sciatica and hot flashes, kept me uncomfortable for the first third of the play. I felt like I was in for a *Waiting for Godot*-type stream-of-consciousness play, and I rolled my eyes in the dark. In spite of my foul mood, the play soon caught me in its spell.

The rhythm of Joan's prose/poetry transported the audience into a space where we did not need to think or analyze, just experience. The sensations of each familiar memory, each familiar stranger, marched through our hearts in a sedate cadence, while big and little life-horrors tinkled a counterpoint.

It is the mark of the artist to be able to communicate so eloquently that everyone can identify with the subject, and Joan has that gift. One unforgettable example was the lion, who slept in the room at night with the child/adult—oppressively, protectively, comfortable, awful beast of familiar fear. So wonderfully executed, choreographed. Shuddering.

I also liked the way the loving family member spoke to her brother in law---speaking directly to the space next to him. It so perfectly illustrated the complaint those who suffer PTSD often feel—unseen, unheard, no one knows him or understands. And the way he felt so compelled to get to work, such anxiety—he might be able prevent a calamity. Joan Fiset says it all so simply.

The actors were wonderful. What a shock to see such professional talent in such a modest venue. And it seemed obvious that a lot of thought—or a lot of professional experience—went into the staging. One never knows exactly whom s/he is watching, yet all the information needed to understand everything is there. The cultural references are very 1950's Americana, woven with plenty of archetypal content, so those born abroad or born too late should be able to relate as well as this audience did.

Other parts I can't resist sharing for those who missed it:

"Yeah, the Lone Ranger, Davey Crockett, Daniel Boone, Howdy Doody.....they aren't in this movie. ...And I've been watching this movie for *years*, now."

The little kid remembering how he got the gold medal for being a leader during a catastrophe--there was a picnic and the parents of the children who died sat in the front row.

So, congratulations Joan Fiset, for all the work you put into this excellent piece. I hope it is played many more times. ##

Movie Review:**House of Bamboo**—Samuel Fuller directed this post-WWII film about criminal ex-GIs

Reviewed by EE

Samuel Fuller reworked a script by Harry Kleiner and turned out a financial and critical success with *House of Bamboo*, a film about “ex-GIs planning crimes like military operations” (p.315). [Fuller, *A Third Face*, Alfred A. Knopf, 2002]. He shows the rogue ex-servicemen as criminals who committed crimes and did time in military service, and then were hand-picked by Sandy Dawson, played by Robert Ryan, to continue their wicked ways, robbing trains and banks in post-war US-occupied Japan.

House of Bamboo was filmed in 1954 and released in 1955, and shows the U.S. influence continuing in Japan. Robert Stack appears first as Eddie Spanier, a tough guy, down on his luck, who was supposed to meet his friend, Griff, in Tokyo. Griff, however, was killed in a robbery that is described by police, and the bullet from a P38 was the same gun that shot a train guard in the film’s opening robbery scene. A U.S. soldier was guarding the train with his Japanese counterpart when they were attacked by the gang of robbers. It took Griff (Cameron Mitchell) two days to die and crucial information was extracted, so that, when Eddie Spanier arrives on the scene, the context implies he’s more than he seems. We find out later that he is a U.S. army sergeant undercover posing as Eddie. He finds Mariko (Shirley Yamaguchi), who was Griff’s secret wife, and they team up as gangster and his “Kimono Girl” to infiltrate the mob of ex-GIs.

Cultures Merging

Fuller, whose own WWII was fought in Africa and Europe, intended to show the contrasts that were played out by Americans in Japan. He intentionally cast tall Americans to stand in contrast with the Japanese. He made ample use of Tokyo streets, and tells in his autobiography about how he released Robert Stack, looking like a down and out tough guy, into the Tokyo alleyways with cameras following him. Fuller describes it beautifully: “Nothing in Stack’s training could have prepared him for *House of Bamboo*. In one early scene, I hid our cameras on a rough Tokyo street where gangs, winos, and derelicts lived. I costumed Bob in an old raincoat, and told him not to shave so that he’d fit right in” (p. 215). Stack was attacked by a street mob and police had to intervene.

Fuller prided himself on casting an Asian as an Asian lead with Shirley Yamaguchi. He also asserts that he was able to slip in a homoerotic scene when Sandy shoots a gangster, his former number one man, who is soaking in a tub, then talks to him affectionately, like Hamlet to poor Yorick, in a manner that reveals his own delusional ego inflation. Fuller’s scenes of Tokyo are a rare look at a re-

covering post-war Japan. He manages to show a love relationship between Stack’s Eddie Spanier and Yamaguchi’s Mariko, in which there are passionate encounters of growing intensity, without an erotic touch or kiss.

The final scenes in *House of Bamboo* were shot in an amusement park setting atop a Tokyo department store. It was used in real life as the department store’s childcare center for shoppers. Fuller got the owner of the store so enthralled with the idea of his film, that the executive volunteered to play the part of a doting grandfather in the climactic scene when Sandy’s gang is hunted down and Eddie and Sandy shoot it out on a bizarre amusement globe reminiscent of the Seattle *PI*’s logo.

Fuller uses the Japanese décor to set the contrasts between the tall Americans shooting pool in a room of delicate paper and wood sliding panels. He shoots a long scene of Sandy, the gang boss, talking to Eddie in a strikingly beautiful shadow of a floral arrangement.

Drafting Bandits

The gun that Sandy uses to kill the guard in the opening train robbery sequence is identified as a P38, a German army handgun. Much is made of this, as it finally ties in Sandy to the killing of Griff. It also gives us an overlay of the kind of social upheaval the Second World War created that turned criminals into GIs, who continued to perpetrate their evils on unsuspecting foreign populations. In this sense, the current film *Buffalo Soldiers* follows a similar theme.

Fuller, as usual, is skillful with his action scenes, and dated in dealing with love-making. He has Eddie Spanier acting like a gosh-gee-whiz hick from the hills when he is embarrassed by the casual way Mariko approaches him in his bath. But Fuller works in the problem of Japanese customs suppressing Mariko’s behavior as she becomes attracted to the Westerner.

All Fuller’s films were shot on tight budgets and the final scene of Eddie, now in army uniform, walking with Mariko in a park, is clipped and sketchy, as if tacked on to what was really the appropriate finale, seeing Sandy’s corpse draped over the railing of the entertainment wheel, rotating.

For those who love Japanese cinema, Sessue Hayakawa plays the Japanese police Inspector Kito. The actors who seem to get the most out of the film, however, are the two tall tough guys, Robert Stack and Robert Ryan. While Stack’s character prevails, Ryan’s has the best lines with his arrogance directing the planning of robberies as if they were military operations. What Fuller thought was homoerotic nuance in 1954 seems to pass us by today, jaded as we are with celebrities prancing into public office. ##

Debriefers Attempt to Prevent Military PTSD

The controversy over the utility of debriefing after events that are potentially traumatic was taken up recently in a slick newspaper, *US Medicine: The Voice of Federal Medicine* [2003, 39(10), pp 1, 36-7]. The page one article, authored by Matt Pueschel, is based mainly on an interview with Cdr. Bryce LeFever, Ph.D., MSC, USN, who worked with Special Forces in Afghanistan in 2002. Cdr. LeFever conducted debriefings "at the time of soldier's redeployments or after particularly traumatic or shocking combat incidents. For many soldiers who are very young and inexperienced, 'in a sense there were a lot of times where they don't know what to think about the incident. We give them a healthy way to remember it—to put it in its place'" (p. 1). Cdr. LeFever said, "Everybody feels strange after such incidents, and the debriefers are there to try to impart that to the soldiers, as well as acknowledge their hard work in the field" (p. 1).

In the procedure described by the author, the debriefer "asks the unit to go over the facts of the event, what happened, what they did, and what thoughts have gone through their minds at the time. The conversation then tries to get the soldiers to discuss their emotional reactions to the experience" (p. 36). The symptoms that can emerge from the experience are described and the debriefer talks about how to manage the symptoms, emphasizing avoiding alcohol and substance abuse.

The Controversy

Regarding the controversy around the utility of debriefing, Cdr. LeFever said, "You should not provide in-depth counseling prior to the termination of the incident, or a series of events or combat missions. While these missions are part of daily routines, we want to support the troops, by and large. We just say, 'you're doing a good job, we're proud.' After the mission is completed we work with the soldier to process the event so that he can make a successful transition to his more normal life at home" (p. 36).

The use of critical incident debriefing process was described in a manner very much reminiscent of traditional theory of military psychiatry. The author writes: "Cdr. LeFever wrote that the use of CISM techniques fall under five basic management guidelines for treating combat stress: immediacy—treating the casualty as soon as possible; proximity—treat the psychiatric casualty as close to the front line and his or her unit as possible; normalcy—do not treat the casualty as a psychiatric patient, but deal with his or her immediate concern or trauma; familiarity—return the soldier to his or her original unit as soon as possible; and expectancy—create the expectancy that the soldier will recover quickly and will return to their (sic) normal level of functioning" (p. 36).

Families of Trauma Casualties Involved

In an observation that the federal Department of Veterans Affairs could well heed, Cdr. LeFever said "PTSD has a ripple effect that affects the people who were closest to the trauma the most, but spreads out to those who were associated with it in other ways, as well as the families of victims and first responders. Ideally, if the Army had enough resources, it would reach out to the families of those afflicted with PTSD, as well" (p. 37).

Cdr. LeFever observed, "I think the answer is taking care of the immediate community" (p. 37).

Treating Chronic PTSD

Cdr. LeFever was head of the Substance Abuse Rehabilitation Program at the Naval Medical Center in Portsmouth and observed that "chronic substance abuse problems can have roots in trauma and PTSD. He said that treatment is a lot harder to do with soldiers who went through something years ago and were never debriefed afterwards or never talked about it before. A large part of it is getting them to get in touch with the emotional impact of what they witnessed or went through, so they can begin to process it" (p. 37).

Comment

The Commander's words stand in contrast to the WWII ethic displayed by General Patton when he slapped the man with malaria whom he thought was shaking with fear. One also wonders what the troops in the field, the old salts, call the debriefers. EE ##

The Repetition & Avoidance Quarterly is published each season of the year by The Washington Veterans PTSD Program, of the Washington Department of Veterans Affairs. The PTSD program's director is Tom Schumacher. The editor of the *RAQ* is Emmett Early. It is intended as a contractors' newsletter for the communication of information relevant to the treatment of PTSD in war veterans and their families. Your written or graphic contribution to the PTSD Program newsletter is welcomed if it is signed, civilized, and related to our favorite topics of PTSD and war veterans. Contributions may be sent by mail to the Washington Department of Veterans Affairs (Attn: Tom Schumacher), PO Box 41150, Olympia, WA 98504, or by Email directly to <emmett@dva.wa.gov>. Readers are also invited to send in topical research or theoretical articles for the editorial staff to review. Comments on items reported in the *RAQ* are also encouraged and will likely be published if they are signed. To be included in our mailing list, contact WDVA, Tom Schumacher, or Emmett Early. The *RAQ* can also be read online by going to www.dva.wa.gov Once in the WDVA Website, click on "PTSD", and once on the PTSD page, scroll to where you find access to the *RAQ*. The newsletter logo is a computerized drawing of a photograph of a discarded sign, circa 1980, found in a dump outside the La Push Ocean Park Resort. ##